

**PATIENT INFORMATION**

(please print)

Date: \_\_\_/\_\_\_/\_\_\_

Name (Last, First, MI)

Mailing Address (Street, Apt., City, State, Zip Code)

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Sex \_\_\_ Marital Status \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**OTHER ADDRESS or PARENT OR RESPONSIBLE PARTY (if different from patient)**

Name (Last, First, MI)

Mailing Address(Street, Apt., City, State, Zip Code)

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex \_\_\_\_\_ Relationship: \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**INSURANCE INFORMATION (please present insurance card at time of check-on)**

Primary Insurance Name \_\_\_\_\_

Ins. Address \_\_\_\_\_

Name of Insured \_\_\_\_\_

Insured's ID# \_\_\_\_\_

Group # \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Relationship of patient to insured \_\_\_\_\_

Secondary Insurance Name \_\_\_\_\_

Ins. Address \_\_\_\_\_

Name of Insured \_\_\_\_\_

Insured's ID# \_\_\_\_\_

Group # \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Relationship of patient to insured \_\_\_\_\_

Other family member that are patients \_\_\_\_\_

Pharmacy of choice \_\_\_\_\_ Phone \_\_\_\_\_

In case of an emergency, who should be notified ? \_\_\_\_\_ Phone \_\_\_\_\_

Referred by: \_\_\_\_\_

I authorize the release of medical information to my referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

By signing below, I state that the above information is true and correct. I will inform this office of any changes that are made as they occur.

**Patient or Responsible Party Signature:**

\_\_\_\_\_ **Date** \_\_\_/\_\_\_/\_\_\_